1.0 Purpose:

- To provide detailed records for all patients and their medical care in the organization.

- To provide guidelines to those who are involved in taking care of the patients during Out Patient consultation and Admission in the organization.

2.0 Scope:

To furnish details about those who are involved in taking care of the patients during Out Patient consultation and admission from the organization.

3.0 Responsibility:

All Consultants, Duty Doctors, Nurses, Physiotherapist, Dietician, Social worker and front office staff.

4.0 **Policy:**

To provide details about the patient and their care. The medical record must contain patient's identification data, Clinical Information, the data must be legible, every entry in medical record must be dated and its author name or employee code no.& time must be known.

Authorized staffs are those who are involved in taking care of the patient during the admission (or) Out Patient consultation.

4.1 Consultant / Registrar / Duty Doctors:

Admission order

Order to admit the patient.

Initial assessment

History & physical examination of patient

Progress report, drug chart and non-drug orders

It delivers the details about the patient condition and the drug orders during the stay and at discharge.

In-house transfer order

Shows the details of patient transfer within the hospital.

Patient condition

It shows the patient condition at the time of patient discharge

Transfer of the patient

It gives detail about patient transfer from one place to another place(mentioned in Progress Notes)

Risk of transfer

It shows the risks when patients are shifting one place to another place.

Anesthesia forms

It denotes the mode of anesthesia details of anesthetics, and patient condition.

Operation notes & Post operative orders

It clearly denotes name of operation done to the patient.

Post operative orders shows the patient condition after operation, follow up notes and instructions.

Discharge Medications

It shows after the patient discharge, how can be follow the medication quantitatively.

Discharge order of patient

The order to discharge the patient.

Informed Consents for;

Procedures, Surgery, Anaesthesia, Treatment, Blood Transfusion, Conscious sedation, Restraints.

4.2 DMO / EMO / REGISTRAR:

- To write A.R COPY / POLICE INTIMATION
- To fill up the wound certificate
- To write the discharge summary / discharge against medical advice form
- To fill up the emergency records
- To make entry in all consent forms,
- To make entry in case sheets and also in drug chart.

4.3 STAFF NURSES

- Nurses Chart
- Input/ Output chart
- Clinical chart
- Drug chart (Administration of drugs)
- Nursing Assessment chart
- Master Chart
- Pre operative checklist
- Investigation / Test reports
- Discharge checklist

4.4 PARAMEDICAL STAFFS (Physiotherapist, Dietician and social worker):

- Physiotherapist – Functional assessment , physiotherapy progress notes.
- Dietician – Nutritional assessment & Nutritional plan form
- Social worker – Initial assessment, Patient and family education

4.5 FRONT OFFICE STAFF

To sign in the general consent and noting down the financial details in the admission order.

4.6 CONTENTS FOR INPATIENTS:

Discharge Summary with date of admission, discharge with the consultant Signature. Admission card, Initial assessments, Surgical record (Pre anesthesia assessment, consent forms, High risk consent form anesthetic forms, pre operative forms, operation notes, post operative notes), progress sheet, , investigation chart, , nursing assessment, nurses clinical chart , nurses chart, drug chart, intake and output chart, daily master charts for critical patients, physiotherapy records, discharge against Medical Advise form, MLC & Death Certificate. All the forms must be legible, entries must be completed with date and signature(in case of e-records e-signature are used).